

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **14176**

FILED APR 21 1955

BIRTH NO. **27427-55** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **544** Registrar's No. **741**

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). | | | |
| a. COUNTY ST. Louis | | | | a. STATE MISSOURI b. COUNTY ST. Louis | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood | | c. LENGTH OF STAY (in this place) 4 hrs | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood 4722 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. Joseph - Hospital | | | | d. STREET ADDRESS (If rural, give location) 804 N. BALLAS Rd | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) MARY | | b. (Middle) Kathleen | | c. (Last) CAHILL | |
| 4. DATE OF DEATH | | 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER-MARRIED | |
| 8. DATE OF BIRTH 3-31-55 | | 9. AGE (In years last birthday) — | | 10. IF UNDER 1 YEAR Days — | | 11. IF UNDER 1 MIN. Min. — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (City and State or Foreign Country) Kirkwood MO | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME John T. Cahill | | 13b. MOTHER'S MAIDEN NAME MARY-E. HARRIS | | 14. NAME OF HUSBAND OR WIFE NIL | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME John T. CAHILL ADDRESS 804 N. BALLAS Rd | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH 7 hr. | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immaturity | | ANTECEDENT CAUSES | | | | | |
| | | DUE TO (b) pregnancy | | | | | |
| | | DUE TO (c) placenta previa | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. MAJOR FINDINGS OF OPERATION 7615 | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) — | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) — | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? — | | | |
| 22. I hereby certify that I attended the deceased from Birth , 19 3/31 , 1955, to 3/31 , 1955, that I last saw the deceased alive on 3/31/55 , and that death occurred at 2:00 p.m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE W. A. Smith (Degree or title) MD | | 23b. ADDRESS 110 S. Central | | 23c. DATE SIGNED 4-1-55 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE 4-1-55 | | 24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem | | 24d. LOCATION (City, town, or county) (State) ST. Louis Co MO | |
| DATE RECD BY LOCAL REG. 4/1/55 | | REGISTRAR'S SIGNATURE Heather A. Smith | | 25. FUNERAL DIRECTOR'S SIGNATURE W. B. Smith ADDRESS Maplewood 17 MO | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

NOT EMBALMED - 4-6-55
N. W. Brown - Jay B. Smith
Funeral Home

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.